Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

# Independent Healthcare Inspection (Announced)

## Cyncoed Consulting Rooms, Cardiff

12 August 2015

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# Contents

## 1. Introduction

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales.

HIW's primary focus is on:

- Making a contribution to improving the safety and quality of healthcare services in Wales
- Improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee
- Strengthening the voice of patients and the public in the way health services are reviewed
- Ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

HIW inspections of independent healthcare services seek to ensure services comply with the Care Standards Act 2000 and requirements of the Independent Health Care (Wales) Regulations 2011 and establish how services meet the National Minimum Standards (NMS) for Independent Health Care Services in Wales[1].

This report details our findings following the inspection of an independent health care service. HIW is responsible for the registration and inspection of independent healthcare services in Wales. This includes independent hospitals, independent clinics and independent medical agencies.

We publish our findings within our inspection reports under three themes:

- Quality of the patient experience
- Delivery of safe and effective care
- Quality of management and leadership.

[1] The National Minimum Standards (NMS) for Independent Health Care Services in Wales were published in April 2011. The intention of the NMS is to ensure patients and people who choose private healthcare are assured of safe, quality services. http://www.hiw.org.uk/regulate-healthcare-1

## 2. Methodology

During the inspection we gather information from a number of sources including:

- Information held by HIW
- Interviews with staff (where appropriate) and registered manager of the service
- Conversations with patients and relatives (where appropriate)
- Examination of a sample of patient records
- Examination of policies and procedures
- Examination of equipment and the environment
- Information within the service's statement of purpose, patient's guide and website (where applicable)

At the end of each inspection, we provide an overview of our main findings to representatives of the service to ensure that they receive appropriate feedback.

Any urgent concerns that may arise from an inspection will be notified to the registered provider of the service via a non-compliance notice[2]. Any such findings will be detailed, along with any other improvements needed, within Appendix A of the inspection report.

Inspections capture a snapshot on the day of the inspection of the extent to which services are meeting essential safety and quality standards and regulations.

[2] As part of HIW's non-compliance and enforcement process for independent healthcare, a non compliance notice will be issued where regulatory non-compliance is more serious and relates to poor outcomes and systemic failing. This is where there are poor outcomes for people (adults or children) using the service, and where failures lead to people's rights being compromised. A copy of HIW's non compliance process is available upon request.

## 3. Context

Cyncoed Consulting Rooms is registered as an independent hospital to provide consultations and out-patient services. It is situated at 277 Cyncoed Road, Cardiff, CF23 6HX.

The service was first registered on 5 December 2005.

The service employs a staff team which include a manager, who is currently seeking registration with HIW, clinicians, clinical therapists, registered nurses and reception personnel.

HIW completed an announced inspection to Cyncoed Consulting Rooms on 12 August 2015.

Further information about Cyncoed Consulting Rooms and the services it provides can be found on its website[3].

[3] www.cyncoedconsultingrooms.co.uk

## 4. Summary

Overall, patients were positive about the quality of the service provision and the treatment provided. We found that the service recognised and addressed the individual needs of patients and that overall patients' rights to dignity and respect were protected. The statement of purpose and patient's guide required some updating. Some revision work had been undertaken before the end of our visit.

The service had policies and procedures in place with the intention of providing a safe service. We noted that a policy and procedure was not available with regard to data protection and required record retention. It was noted that the service would benefit from having a system in place to review policies for their content and version control. Contracts were in place with regard to clinical waste and facility maintenance. However, it was advised that the patient's toilet floor area may require reviewing. It was noted that not all information was available with reference to storage and disposal of medications. We observed that there was no record of testing of the ophthalmology equipment and the resuscitation equipment was not checked on a daily basis to ensure it was safe to use. This was discussed with senior staff during the inspection. We also observed that staff fire drills were overdue and the fire risk assessment required reviewing i.e. signage and fire exits

We recommended that information on how to make a complaint should be made available in either the reception and/or waiting area. There were no recent audits and/or monitoring undertaken of the service's performance to identify where they could make improvements to patient treatment and care. There were no reports resulting from a provider's visit and no annual report was available. Required information was not available in all staff files.

We identified areas for improvement and regulatory breaches during this inspection which is detailed within Appendix A of this report. Whilst this has not resulted in the issue of a non compliance notice, there is an expectation that the registered provider takes meaningful action to address these matters, as a failure to do so could result in HIW taking action in accordance with our non-compliance and enforcement process.

## 5. Findings

### *Quality of the patient experience*

**Overall, patients were positive about the quality of the service provision and the treatment and care provided. We found that the service recognised and addressed the individual needs of patients and that overall, patients' rights to dignity and respect were protected. We identified that a copy of the statement of purpose and patient's guide required updating. Both also needed to be made available to people using the service. This has now been actioned and completed.**

**Care Planning and Provision (Standard 8)**

No patient documentation is held at the setting, patient documentation is kept by the individual clinician and/or therapist. We noted that there was no policy and/or protocol available to ensure that clinicians and therapists comply with data protection laws, back-up the data, and ensure that it is retrievable with reference to required retention periods. It is advised that all clinicians and therapists sign this policy. A record should be made available from Spire referrals with regard to individual appointments i.e. treatment, review, and assessment. The hospital should maintain a record of room use for audit purposes and also to ensure that the most appropriate room is allocated for the appointment. HIW have been advised that both of the areas noted above have been actioned by the manager.

We noted that in one case, that patient's documentation had been left unattended in a consulting room. This was brought to the attention of the manager and HIW have been advised that appropriate action has been undertaken.

***Improvement needed***

***Ensure that confidential information is secure at all times.***

**Patient Information and Consent (Standard 9)**

We were informed that patient's queries, concerns and questions were taken into account throughout the consultation and treatment planning process. Patients could also express their views and any concerns throughout the consultation and treatment process. However, formal arrangements need to be put in place to seek patient feedback. Patients need to be made aware of results and/or outcomes annually. It may be helpful to use a suggestion box to promote and assist in feedback. HIW have been advised that appropriate action has been undertaken.

**Dignity and Respect (Standard 10)**

There were privacy and dignity and equality and diversity policies available. The statement of purpose and the patients guide notes that a chaperone service is available, if required. A policy statement needs to be made available and a sign should be displayed in the waiting areas to inform patients of this service. HIW have been advised that appropriate action has been undertaken. There were consulting rooms with appropriate signage used when the room was occupied, to help ensure patient privacy. The environment provided both open and private areas for patients and family members and/or accompanying supporters.

**Communicating Effectively (Standard 18)**

It was noted, from viewing a sample of responses to the provider's patient questionnaire, that patients praised the quality of the service and rated the service provision very highly. There were also a number of positive personal comments. However, we noted that outcomes from patient feedback were not displayed and/or available within the patients guide. We recommended that feedback from patient questionnaires should be made available to staff as well as patients.

A statement of purpose and patient's guide were available. However, patients need to be made aware that these documents are available for patients, family members and/or carers to view, should they wish to do so.

***Improvement needed***

***The statement of purpose and patients guide should be made available to all relevant personnel. It should be updated in line with service provision.***

***To ensure the patient guide is routinely updated to include the findings from patient questionnaires.***

A patient information leaflet was also available within the waiting area. We identified aspects of patient information and documentation which required review and improvements. This included offering services which were no longer available. HIW have been advised that the leaflet has been withdrawn.

We looked at how the service considered individual communication and language needs. We found that patient information was only available in English. We noted that there was no language line facility was available. There was an expectation that patients will supply a translator, if required. No loop system was available for individuals who have impaired hearing. HIW have been advised that a patient survey is being undertaken with regard to utilising this system.

## *Delivery of safe and effective care*

**The service takes steps to ensure that patients are provided with safe and effective care. For example, there are policies and procedures in place and appropriate arrangements in to maintain equipment and for the removal of clinical waste. However, further action needs to be taken, given the issues found during this inspection.**

**Safe and Clinically Effective Care (Standard 7)**

The service was managed by staff who were clinically trained. However, we noted that clinical governance required strengthening at all levels; this is because we found the following areas for improvement:

- There was a lack of information regarding current policies, procedures and processes available.
- There was a lack of information with regard to practice based protocols, practice, pathways and procedures for clinical work
- We found that although individual clinicians monitored their own performance and clinical outcomes, there were no performance indicators available. Performance indicators assist with clinical audit which is an integral aspect of service improvement. ..

***Improvement needed***

***Central policy index listing current policy version number and date of policy renewal.***

***Information with reference to evidence and practice based protocols, practice, pathways and procedures for clinical work should be available within the hospital.***

***Clinicians must make available/supply current copies of their certificates of practice, insurance and their most recent appraisal.***

**Safeguarding Children and Safeguarding Vulnerable Adults (Standard 11)**

We found that some improvements were needed to ensure that the welfare and safety of children and adults who become vulnerable or at risk is protected at the service. We noted that the service did not have a safeguarding policy available. HIW have been advised that a policy and procedure is now in place. Staff had previously received training in safeguarding and further training was to be organised. We were informed that there had been no safeguarding concerns or incidents to date. There was no designated person responsible for safeguarding children and vulnerable

adults. It is advised that a safeguarding lead be appointed to assist in this area. The service was also asked to review the practice of 'mixed' clinics. i.e. children and adults attending for appointments at the same time. This is because it is a regulatory requirement that children are treated in separate accommodation from adult patients.

***Improvement needed***

***Children's appointments should be made at a time, when adult appointments have not commenced and/or end of the day. A separate part of the building should be designated for children only, when there are child appointments.***

**Infection Prevention and Control (IPC) and Decontamination (Standard 13)**

There were schedules in place for cleaning and there were contracts with regard to clinical waste and facility maintenance. However, it was noted that the patient's toilet had an unpleasant odour and the flooring required attention. The hot water temperature in the hand basin requires reviewing. It may be advisable to seek advice with regard to having a thermostatic mixing valve fitted.

***Improvement needed***

***Patient's toilet area requires attention.***

**Medicines Management (Standard 15)**

We noted that a full record was not available of all Vaccines/Medicines. The record needs to include dates of expiry, method and date of disposal.

***Improvement needed***

***A full record must be kept of all Vaccines/Medicines to include dates of expiry, method and date of disposal.***

**Medical Devices, Equipment and Diagnostic Systems (Standard 16)**

It was noted that daily checks on the resuscitation equipment were not carried out and outcomes recorded. HIW have been advised that this procedure is now in place. We also found that the test outcomes of the opthalmology equipment were not available. This was discussed with the registered manager during our visit.

***Improvement needed***

***The resuscitation equipment should be checked daily and outcomes recorded.***

***The test outcomes of the opthalmology equipment must be made available.***

## Managing Risk and Health and Safety (Standard 22)

We noted that no fire drills had been undertaken and/or recorded for a lengthy period of time. We advised that fire exit signs and assembly point signs were checked in accordance with the fire risk assessment and that all staff members including clinicians and therapists attend a fire drill. A record should be kept of attendees. Health and Safety training was overdue. The manager has organised training and is awaiting dates.

***Improvement needed***

***Staff, clinicians and therapists need to attend fire drill.***

***Fire exit and assembly signs should be checked against fire risk assessment***

## Dealing with Concerns and Managing Incidents (Standard 23)

The service has a complaints policy and procedure in place. There had been one verbal complaint in 2015. However, we found there was no notice in either the reception and/or waiting area informing patients about how to make a complaint.

***Improvement needed***

***Patients should be made aware of how to make a complaint and the hospital's complaint procedure.***

## *Quality of management and leadership*

**The service has not undertaken any recent audits and/or monitored its performance to identify where they could make improvements to patient treatment and care. We found, no audit and/or analysis outcomes reports and no reports resulting from a provider's visit and/or an annual report were available.**

**Governance and Accountability Framework (Standard 1)**

The manager was present on the day of the visit.

We found the service clinical governance framework required strengthening at all levels. This is because the service had not been sufficiently proactive in assessing and monitoring the quality of service provision, in accordance with regulatory requirements. We found there was no information available to demonstrate that the service had recently audited and/or monitored its performance to identify where they could make improvements to patient treatment and care. There were no reports resulting from a provider's visit and/or an annual report available at the time of our inspection in accordance with regulatory requirements.

***Improvement needed***

***The service should ensure there is a clinical governance and quality assurance policy, processes and protocols in place which includes the requirements as outlined in the Independent Healthcare (Wales) Regulations for registered provider visits and an annual report to be completed. The service must undertake these requirements on an ongoing basis.***

**Workforce Recruitment and Employment Practices (Standard 24)**

Staff appraisals were to be undertaken with a personal development plan to meet identified needs. Staff training was being organised within the service by the manager. It was noted that some staff personnel files did not contain required information. References must be available for all staff members. If historically these were not available, a cover sheet with present character references is sufficient. HIW have been advised that a process is now in place to ensure that all staff files have two references.

***Improvement needed***

***The service should ensure that all staff files contain two references.***

## 6. Next Steps

This inspection has resulted in the need for the service to complete an improvement plan in respect of quality of patient experience and quality of management and leadership. The details of this can be seen within Appendix A of this report.

The improvement plan should clearly state how the improvement identified at Cyncoed Consulting Rooms, Cardiff will be addressed, including timescales.

The improvement plan, once agreed, will be published on HIW's website and will be evaluated as part of the ongoing inspection process.

*Appendix A*

## Improvement Plan

## Service: Cyncoed Consulting Rooms (Cardiff)

## Date of Inspection: 12 August 2015

| Page Number | Improvement Needed | Regulation / Standard | Service Action | Responsible Officer | Timescale |
|---|---|---|---|---|---|
| **Quality of Patient Experience** | | | | | |
| 8 | 1. The Statement of Purpose and Patients Guide should be reviewed in line with service provision and made available to patients and other appropriate personnel.<br>2. Review, update and make available patient questionnaire feedback from 2014 | Regulation 6<br>Schedule1<br>Regulation 7 (1)(e) | | | |

| Page Number | Improvement Needed | Regulation / Standard | Service Action | Responsible Officer | Timescale |
|---|---|---|---|---|---|
| | 3. Ensure that confidential information is secure at all times. | Regulation 23 (2)(a) | | | |
| **Delivery of Safe and Effective Care** | | | | | |
| 9 | 4.Central policy index listing current policy version number and date of policy renewal.<br><br>5. Information with reference to evidence and practice based protocols, practice, pathways and procedures for clinical work should be available within the hospital.<br><br>6. Clinicians must make available/supply current copies of their certificates of practice, insurance and their most recent appraisal. | Regulation 9(5)(6)<br><br>Regulation 9(1)(o)<br><br>Regulation 21(2)(b)(d) | | | |

| Page Number | Improvement Needed | Regulation / Standard | Service Action | Responsible Officer | Timescale |
|---|---|---|---|---|---|
| | 7. Patient's toilet area requires attention. | Regulation 26(2)(a) | | | |
| | 8. A record must be kept of all Vaccines/Medicines to include dates of expiry, method and date of disposal. | Regulation 15(5)(a) | | | |
| | 9. The resuscitation trolley should be check daily and outcomes recorded. | Regulation 15(5)(c)(ii) | | | |
| | 10. The test outcomes of the opthalmology equipment must be made available. | Regulation 15(2) | | | |
| | 11. Children's appointments should be made at a time, when adult appointments have not commenced and/or end of the day. A separate part of the building could be designated for children's use only, when required | Regulation 39(a) | | | |

| Page Number | Improvement Needed | Regulation / Standard | Service Action | Responsible Officer | Timescale |
|---|---|---|---|---|---|
| | 12. Staff, clinicians and therapists need to attend fire training/ drill. | Regulation 26(4)(b) | | | |
| | 13. Fire exit and assembly signs should be checked against fire risk assessment. | Regulation 26(4)(b)(c) | | | |
| | 14. Patients should be made aware of how to make a complaint and the hospital's complaint procedure. | Regulation 24 (3)(a)(b) | | | |
| **Quality of Management and Leadership** | | | | | |
| | 15. The service should ensure there is a clinical governance and quality assurance policy in place which includes the requirements as outlined in the Independent Healthcare | Regulation 28 (3)(4)(c) | | | |

| Page Number | Improvement Needed | Regulation / Standard | Service Action | Responsible Officer | Timescale |
|---|---|---|---|---|---|
| 11 | (Wales) Regulations for registered provider visits and an annual report to be completed. The service must undertake these requirements on an ongoing basis.<br><br>The service should ensure that all staff files contain two references. | Regulation 21(2)(d) Schedule2 (4) | | | |

**Service Representative:**

**Name (print):** .....

**Title:** .....

**Date:** .....